



Opioid policies checklist

Use this checklist when revising your opioid policies to confirm alignment with evidence-based guidelines. The recommended topics to include come from the [CDC Guideline for Prescribing Opioids](#) and [Washington State opioid prescribing rules](#).

Do your opioid policies cover the following topics?

Continuity of care

- In most cases, it is important to continue to provide health care to patients, even if you are no longer prescribing opioids.
- In some cases the organization might consider discontinuing health care to the patient, such as for persistent, unacceptable, inappropriate behavior with staff or clinicians.

General rules for all opioid prescribing

- Only prescribe opioids if the patient has a diagnosis for pain that will benefit from opioids.
- Prescribe the lowest effective dose of immediate-release opioids. Avoid doses of ≥ 50 MED.
- Do not prescribe opioids for non-specific axial (mechanical) low back pain, fibromyalgia, and chronic headaches.
- Refer to [assessment schedule](#) for information on recommended care processes for patients using opioid medications.

Pain and function

- Only consider opioid therapy if the expected benefits for pain and function are anticipated to outweigh risks to the patient.
- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with the patient, including realistic goals for pain and function.
- Only continue opioid therapy if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Use of non-opioid and non-pharmacological therapies

- Encourage the use of evidence-based non-opioid and non-pharmacological modalities whenever reasonable and clinically appropriate.

Prescribing opioids for acute (<6 weeks) and subacute (6-12 weeks) pain

- Prescribe no more than 7 days of opioids for acute pain.
- Do not prescribe methadone or extended-release opioids for acute pain.
- Prescribe no more than 14 days of opioids for subacute pain.



Prescribing opioids for chronic pain (>12 weeks)

- Within 1 to 4 weeks of prescribing opioid therapy for chronic pain, evaluate benefits and risks; only continue opioid therapy if there is clinically meaningful improvement in pain and function that outweighs risks to the patient.
- Patients should receive prescription refills from only one clinician (or their designee if not available).

Co-prescribing of opioids and sedatives

- Do not co-prescribe opioids and the following medications without documentation in the record, discussion of risks, consultation with the patient's other prescribers, and consideration of tapering:
 - Benzodiazepines, barbiturates, sedatives, carisoprodol, non-benzodiazepine hypnotics
- If co-prescribing opioids and sedatives to a patient who has come to your practice on these medications, begin tapering when appropriate and within 3 months of initiating care for the patient. Engage the patient in the process by deciding which to taper and at what rate. The tapering plan can change over time (e.g., which medicine tapered can alternate back and forth between sedative and opioid; tapering rate can change).

Risk

- Assess overdose risk before the first opioid prescription. Risk factors for overdose include history of overdose, substance use disorder or abuse, sleep apnea, chronic lung disease, and use of any concurrent sedative.
- Assess and document risk level before prescribing opioids for chronic pain (pain lasting longer than 12 weeks).
- Conduct care practices for chronic pain according to risk level (high risk, at least quarterly; moderate risk, at least semiannually; low-risk, at least annually).

Urine drug tests

- Conduct urine drug tests at first subacute or chronic pain visit and then according to risk level.

Monitoring of state prescription data monitoring program database

- Review the patient's history of controlled substance prescriptions using the state prescription data monitoring database before the first opioid prescription, at each transition to a new pain category (acute, subacute, chronic), and then at visits according to risk level.

Patient agreements

- Patient agreements reviewing risks as well as patient and clinician responsibilities for managing therapy are signed by every patient on opioids.



Patient education

- Provide patient with written notification and educate patients about the risks associated with the use of opioids (including opioid dependence), how to securely store opioids; and about the availability and location of disposal sites for unused opioid medications.

Tapering of opioids

- If benefits do not outweigh harms of opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- Slow opioid tapers (e.g., 10% per month) as well as pauses in the taper with a defined resume time allow gradual accommodation to lower opioid dosages and are best practices. If a patient is enthusiastic about tapering, they can increase the rate (e.g., 10% every 2 weeks). Avoid increasing doses once tapering begins by identifying non-opioid strategies for pain flares. The only exception is a new acute pain problem.
- Tapering at 10% per week is reasonable for patients in the acute and subacute phase.
- When to begin a tapering protocol, what kind of tapering protocol, and what to do if the patient does not follow the tapering protocol. (See model policy for recommended policy approaches.)

Use of naloxone

- Prescribe naloxone (nasal or injectable) if the patient is prescribed ≥ 50 MED daily, is at risk for overdose, is on sedatives, has opioid use disorder, or is at risk of respiratory suppression due to sleep apnea or chronic lung disease.

Opioid use disorder

- Assess for opioid use disorder in the case of concerning behavior. Assess for potential for substance/opioid misuse, abuse, or disorder at the first subacute or chronic pain visit.
- If you identify that a patient has opioid use disorder, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral to behavioral health services, if available.

Pain specialist consultation

- If the patient is taking opioid medication at an MED ≥ 90 , consider a pain specialist consultation. A pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose, or reasonable attempts to obtain consultation have failed.

Documentation

- Transitions from acute to subacute to chronic pain treatment
- Risk level and related intervals for pain visits
- Specific diagnosis for pain that will benefit from opioid medication
- Plan for treatment (e.g., physical therapy, opioid medication, non-opioid pharmacologic therapies)



- Why the patient's level of function or pain control justifies a continuation of opioids
- That you educated the patient about risks, storage, and safe disposal
- Concerns discovered when checking the PDMP
- Patient agreement signed
- Justification for co-prescribing benzodiazepines, barbiturates, sedatives, carisoprodol, or non-benzodiazepine hypnotics; an opioid dosage ≥ 50 MED; any deviation from clinic policies

